1515 Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
1-800-472-2363 or 715-221-9555
TTY 1-877-727-2232 or 715-221-9898
Fax 715-221-9500

Practice Information

Please attach a copy of your W-9.

Primary office information

Practice name (to whom the check is payable). **This practice name must exactly match the name listed with the IRS and on your federal tax identification number.**

Clinic or office name (if different)

Address

Telephone: Office (day)	Appointment phone number		Fax number
Office hours: M-F	Weekend	Evenings	Urgent Care
Federal tax ID #		NPI	

Clinic/office manager	Telephone

Is this the primary Security Health Plan contact person:

☐ Yes ☐ No If no, provide name

Billing address

(If different than primary clinic site)

Name

Address

Contact person	Telephone

Should this address be used for communications other than billing:

☐ Yes ☐ No

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Additional office information

(If you have more than one additional site, please attach list following this guideline)

Clinic or office name

Address

Telephone: Office (day)	Appointments
Emergency/after hours	
TDD number (if any)	Fax number

Billing address, if different than primary clinic site:

Federal tax ID #	NPI

Clinic/office manager

Telephone

Office hours: M – F	Weekend	Evenings	Urgent Care

Patient access information

What arrangement do your providers have for 24-hours-a-day/7-days-a-week coverage for your patients:

After-hours answering service: ☐ Yes ☐ No 24-hour call coverage: ☐ Yes ☐ No

Usual care for after-hours patient needs:

- ☐ Referred to ER
- ☐ Referred to urgent care
- ☐ Seen by on-call doctor in office
- ☐ Seen by on-call doctor in ER

Other pertinent information ______________________________

____

Other clinic information

Are you a rural health clinic: ☐ Yes ☐ No

If yes, provide your clinic Medicare number ______________________________

Are you state certified as a mental health and/or AODA outpatient facility: ☐ Yes ☐ No ☐ N/A

Is your clinic Medicaid certified: ☐ Yes ☐ No If yes, State of WI billing number ______________

Is your clinic Medicare certified: ☐ Yes ☐ No If yes, Medicare billing number ______________

Do you bill on a HFCA-1500: ☐ Yes ☐ No

Do you have the capability to file electronically: ☐ Yes ☐ No

Provide us with the following practice/facility numbers:

DMERC ______________ CLIA ______________ Mammo ______________

Date form completed ______________________________

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